PROVIDER INVOICE

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES PRV

USE CAPITAL LETTERS ONLY

HFS USE ONLY

1. PROVIDER NAME (FIRST, LAST) | 2. PROVIDER NUMBER | 3. PAYEE | 4. ROLE | 5. EMER | 6. PRIOR APPROVAL

7. PROVIDER STREET | 8. FACILITY & CITY WHERE SERVICE RENDERED

9. PROVIDER CITY | STATE | ZIP | 10. REFERRING PRACTITIONER NAME (FIRST, LAST)

11. RECIPIENT NAME (FIRST, MI, LAST) | 12. RECIPIENT NUMBER | 13. BIRTHDATE | 14. H. KIDS | 15. FAM. PLAN | 16. ST/AB

17. PRIMARY DIAGNOSIS DESCRIPTION | 18. PRIMARY DIAG. CODE

19. TAXONOMY | 20. PROVIDER REFERENCE | 21. REF. PRAC. NO. | 22. SECONDARY DIAG. CODE

23. SERVICE SECTIONS

1 PROCEDURE DESCRIPTION / DRUG NAME, FORM, AND STRENGTH OR SIZE | PROC. CODE/NDC | MODIFIERS | DATE OF SERVICE | CAT. SERV. | DELETE

P.O.S. | UNITS / QUANTITY | MODIFYING UNITS | TPL CODE | STATUS | TPL AMOUNT | TPL DATE | PROVIDER CHARGE

2 PROCEDURE DESCRIPTION / DRUG NAME, FORM, AND STRENGTH OR SIZE | PROC. CODE/NDC | MODIFIERS | DATE OF SERVICE | CAT. SERV. | DELETE

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6 PROCEDURE DESCRIPTION / DRUG NAME, FORM, AND STRENGTH OR SIZE | PROC. CODE/NDC | MODIFIERS | DATE OF SERVICE | CAT. SERV. | DELETE

P.O.S. | UNITS / QUANTITY | MODIFYING UNITS | TPL CODE | STATUS | TPL AMOUNT | TPL DATE | PROVIDER CHARGE

24. OPTICAL MATERIALS ONLY

24A. RX TYPE | 24B. LENS TYPE | 24C. CORRECTION CHANGE

24D. RIGHT SPHERE | 24E. RIGHT CYLINDER | 24F. RIGHT PRISM

24G. LEFT SPHERE | 24H. LEFT CYLINDER | 24I. LEFT PRISM

25. SECT. # | 25A. TPL CODE | 25B. STATUS | 25C. TPL AMOUNT | 25D. TPL DATE

26. SECT. # | 26A. TPL CODE | 26B. STATUS | 26C. TPL AMOUNT | 26D. TPL DATE

27. SECT. # | 27A. TPL CODE | 27B. STATUS | 27C. TPL AMOUNT | 27D. TPL DATE

28. TOT. CHARGE

29. TOT. DEDUCTIONS

30. NET CHARGES

31. #SECT | 32. ORIGINAL DCN | 33. SECT | 34. BILL TYPE | 35. UNCODED TPL NAME

I AGREE TO COMPLY WITH THE REQUIREMENTS IN THE CERTIFICATION WHICH APPEARS ON THE REVERSE SIDE AND IS PART OF THIS BILL.

36. PROVIDER SIGNATURE (DO NOT USE RUBBER STAMP) | 37. DATE

MEDICAID PAYMENTS (Provider Certification)

My signature on the reverse side of this bill certifies that:

All entries on this claim are true, accurate and complete. The services claimed herein have been provided in compliance with the laws and regulations regarding health care services, including but not limited to: the Criminal Penalties for Acts Involving Federal Health Care Programs (42 USC sec. 1320a-7b); State of Illinois Vendor Fraud and Kickback statute (305 ILCS sec. 5/8A-3); and Limitation on Certain Physician Referrals (42 USC sec. 1395nn), Health Care Worker Self-Referral Act (225 ILCS sec. 47/1).

I agree that payment received according to the State's Medical Assistance Program pricing limits will be accepted as payment in full and I will not accept additional payment from any person or persons.

I agree to keep and make available such records as are necessary to disclose fully the nature and extent of services provided and to furnish such information regarding any payments claimed as State and Federal officials may request.

I understand that payment is made from State and Federal funds and that any false claims, statements, or documents, or concealment of material facts may be cause for prosecution or other appropriate legal action.

Services were provided without discrimination on the grounds of race, color, religion, sex, national origin or handicap in accordance with the Civil Rights Act of 1964 and the Rehabilitation Act of 1973.

PLACE OF SERVICE CODES - See Provider Handbook